

# Silver Connect 3

## Individual EPO Plan Benefit Summary



The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Contract. Benefits are limited to services provided by In-Network Providers, except for Emergency Services and certain Mental Health office sessions<sup>1</sup>.

Services provided by Out-of-Network Providers are not covered, except as specifically authorized. Please see the Covered Services section of your plan document for further information.

Plan Features	In-Network Member is responsible for:
<b>Essential Health Benefits</b>	Unlimited
<b>Lifetime Maximum Benefit</b>	Unlimited
<b>Deductible</b>	
<i>Per Covered Person</i>	\$6,000
<i>Per Family</i>	\$12,000
<b>Annual Maximum Out-of-Pocket (Including Deductible and Co-pay / Co-insurance / Costshare)</b>	
<i>Per Covered Person</i>	\$7,900
<i>Per Family</i>	\$15,800
<b>Physician Services</b>	
<i>Primary Care Physician (PCP) Office Visit/Telemedicine</i>	\$30 Co-pay
<i>Specialty Care Physician (SCP) Office Visit/Telemedicine</i>	\$60 Co-pay
<i>Physician Services not received in an office setting</i>	40%**
<b>Preventive Health Services</b>	
<i>Services with an "A" or "B" rating from the U.S. Preventive Services Task Force as mandated by PHSA Section 2713</i>	\$0
<i>Additional preventive services or treatments not mandated by PHSA Section 2713</i>	40%**
<b>Preventive Services for Children and Adolescents</b>	
<i>Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration</i>	\$0
<b>Physician office visits and laboratory tests associated with preventive checkups</b>	
<i>Preventive Services for Adults</i>	\$0
<i>Preventive care and screenings for women supported by the Health Resources and Services Administration</i>	\$0
<b>Immunizations Ages 0 to Adult (per immunization)</b>	
<i>As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713</i>	\$0
<i>Additional immunizations not mandated by PHSA Section 2713</i>	\$12 Co-pay
<b>Inpatient Hospital Services</b>	
<i>Physician Services</i>	40%**
<i>Hospitalization</i>	40%**
<i>Maternity and Newborn Care</i>	40%**
<i>Human Organ Transplant</i>	40%**
<i>Transportation and Lodging</i>	40%**
<i>Unrelated Donor Search</i>	40%**
<i>Skilled Nursing Services - Inpatient, and Physical Medicine and Rehabilitation</i>	40%** 150 Inpatient days per Benefit Year Combined
<b>Outpatient Services</b>	
<i>Emergency Services</i>	40%**
<i>Urgent Care Services</i>	\$100 Co-pay
<i>Outpatient Surgery &amp; Procedures</i>	40%**
<b>Rehabilitation and Habilitative</b>	
<i>Physical Therapy and Manipulation Therapy*** (not including Chiropractic Services)</i>	40%** 20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)
<i>Occupational Therapy***</i>	40%** 20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)
<i>Speech Therapy</i>	40%** Unlimited

Cardiac Rehabilitation	40%** 36 visits per Benefit Year
Pulmonary Rehabilitation	40%** 20 visits per Benefit Year
Chiropractic Services	40%** Prior authorization required for office visits in excess of 26 per Benefit Year
Diagnostic Laboratory, Imaging and Radiology	40%**
Home Health Care	40%** 100 visits per Benefit Year
Private Duty Nursing	40%** 82 visits per Benefit Year, 164 visits Lifetime Maximum
Hospice	40%**
Ambulance Services	40%**
Educational Services	40%**
Durable Medical Equipment	40%**
Orthotics	40%**
Disposable Medical Supplies	40%**
Prosthetics	40%**
<b>Mental Health Services</b>	
Mental Health Office Visit	\$30 Co-pay
Mental Health Services not received in an office setting	40%**
Hospital Inpatient/Residential Treatment	40%**
<b>Substance Abuse</b>	
Outpatient Annual Maximum Benefit (unlimited)	40%**
Inpatient/Residential Annual Maximum (unlimited)	40%**
Medical or Social Setting Detox Annual Max (unlimited)	40%**
<b>Dental Services</b> (only related to accidental injury or for certain members requiring general anesthesia)	40%**
<b>Pediatric Dental</b> (dependent children through age 18)	
Dental Exam	40%**
Basic Dental Care	40%**
Major Dental Care	40%**
Orthodontia (requires prior authorization)	40%**
<b>Pediatric Vision</b> (dependent children through age 18)	
Routine Eye Exam (1 visit per Calendar Year)	40%**
Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Calendar Year) (1 standard frame every other Calendar Year)	40%**
<b>Autism Services</b>	Benefits are based on the setting in which Covered Services are Received <sup>2</sup>
<b>Applied Behavior Analysis (ABA)</b> Requires prior authorization	40%**
<b>Pharmacy Services<sup>4</sup></b>	Retail (30 day supply)
<b>Deductible</b>	Subject to Medical Deductible (Tier 3-4)
Generic (most), Tier 1 (30 day supply)	\$20 Co-pay
Preferred Brand, Tier 2 (30 day supply)	\$50 Co-pay
Other Brand/Non-Formulary, Tier 3 (30 day supply)	40%**
Specialty Formulary Brand/Non-Formulary, Tier 4 (30 day supply)	40%**
Mail Order <sup>3</sup> (90 day supply)	2.5x

\* U&C is used as an abbreviation for Usual and Customary.

\*\* Co-pays/ Co-insurance/ Costshare applies after Deductible is met.

\*\*\*Co-pays/ Co-insurance/ Costshare for Physical Therapy or Occupational Therapy will not exceed the physician office visit once the Deductible is met.

<sup>1</sup> Covered Services include 2 Mental Health sessions per Calendar Year for the diagnosis or assessment of Mental Illness to an Out-of-Network Provider acting within the scope of their license.

<sup>2</sup> Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible/ Co-pay/ Co-insurance/ Costshare than is applicable to other physical health care services covered by this Plan.

<sup>3</sup> Mail order available on maintenance medications only for a 90 day supply.

<sup>4</sup> If a Provider, Pharmacy, or any third party payer waives, discounts, reduces, or indirectly pays the required cost sharing for a particular claim; the waived portion, discounted portion, reduced portion, or indirectly paid portion of the cost share will not apply to or reduce any Deductible or Out-of-Pocket applicable to the Plan.

**All Plans Are Qualified Health Plans**  
(Plans Available Beginning: 1/1/2021)

This is only a brief summary of benefits which is not intended to be comprehensive. Your Individual Health Plan Policy is the governing document for benefit information.